Dr. O'Day
Goodbye TMJ

Health History

Have you ever had any of the following:			If yes, when was the Condition first apparent?
○ YES	○ NO	Head Injury with loss of consciousness	
○ YES	○ NO	Seizures	
○ YES	○ NO	Stroke	
○ YES	○ NO	Heart Attack	
○ YES	○ NO	Rheumatic Fever	
○ YES	○ NO	Rheumatic Heart Disease	
○ YES	○ NO	Heart Murmur	
○ YES	○ NO	Congestive Heart Failure	
○ YES	○ NO	Angina	
○ YES	○ NO	Cardiovascular Disease	
○ YES	○ NO	High Blood Pressure	
○ YES	○ NO	Tumor or Cancer	
○ YES	○ NO	High Cholesterol	
○ YES	○ NO	Diabetes	
○ YES	○ NO	Thyroid Condition	
○ YES	○ NO	Incontinence	
○ YES	○ NO	Asthma	
○ YES	○ NO	Emphysema	
○ YES	○ NO	COPD	
○ YES	○ NO	Liver Disease	
○ YES	○ NO	Kidney Disease	
○ YES	○ NO	Sleep Apnea	
○ YES	○ NO	Alcohol Abuse	
○ YES	○ NO	Drug Abuse	
○ YES	○ NO	Osteoarthritis	
○ YES	○ NO	Rheumatoid Arthritis	
○ YES	○ NO	Psoriasis	
○ YES	○ NO	Stomach Ulcers	
○ YES	○ NO	Tuberculosis	
○ YES	○ NO	Depression	
○ YES	○ NO	Anxiety	
○ YES	○ NO	Anemia	
○ YES	○ NO	Venereal Disease	
○ YES	○ NO	Do you see your physician on a regular basis? When was your last physical?	
○ YES	○ NO	Are you currently being treated for any chronic illness? If so, please list	

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Health History Continued

Please list all medications that you have taken in the **last six months**, dosages and frequency.

Medication	Dosages	Frequency

○YES ○NO Are you allergic to any medications that you know of?

If yes, please list.

_____

_____

_____

○YES ○NO Are you allergic to Latex?

WOMEN

○YES ○NO Are you or do you think you may be pregnant?
If so, what is your due date? _____

_____ _____

Signature **Date**